Guidelines for Clinical Diagnosis and Documentation of Attention-Deficit/Hyperactivity Disorder (ADHD) in Adults for Non-standard Testing (NST) on the Connecticut Bar Examination.

(Adapted from Consortium on ADHD Documentation)

Preface

These materials were adapted from a document developed by a group of professionals from various organizations who formed the Consortium on ADHD Documentation. The Consortium's mission was to develop standard criteria for documenting attention-deficit disorder, with or without hyperactivity (ADHD), that could be used by post-secondary personnel, licensing and testing agencies, and consumers requiring documentation to determine appropriate accommodations for individuals with ADHD.

Although the more generic term, Attention-Deficit Disorder (ADD), is frequently used, the official nomenclature in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV [American Psychiatric Association], 1994) is Attention-Deficit/Hyperactivity Disorder (ADHD) and is used in this document.

Introduction

This document provides bar applicants and their professional diagnosticians with a common understanding and knowledge base of the components of documentation that are necessary to validate the existence of ADHD, the impact of ADHD on the individual's educational performance, and the need for accommodations for applicants seeking non-standard testing on the Connecticut bar examination. The information and documentation to be submitted should be comprehensive in order to avoid or reduce unnecessary time delays in decision making.

Under the Americans with Disabilities Act (ADA), individuals with disabilities are protected from discrimination and assured services. To establish that an individual is covered under the ADA, the documentation must indicate that the disability *substantially limits* some major life activity, including learning. The following documentation requirements are provided in the interest of assuring that documentation of ADHD demonstrates an impact on a major life activity, is appropriate to verify eligibility, and supports the request for accommodations, academic adjustments, and/or auxiliary aids.

In the main section of the document, information is presented in four important areas: (1) qualifications of the evaluator; (2) recency of documentation; (3) comprehensiveness of the documentation to substantiate the ADHD; and (4) evidence to establish a rationale to support the need for accommodation(s). Appendix A provides the diagnostic criteria for ADHD from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV [American Psychiatric Association], 1994). Appendices B and C provide recommendations for consumers and suggestions for assessment.

Documentation Requirements

I. A Qualified Professional Must Conduct the Evaluation

Professionals conducting assessments and rendering diagnoses of ADHD and making recommendations for accommodations must be qualified to do so. Comprehensive training and relevant experience in differential diagnosis and the full range of psychiatric disorders are essential.

The following professionals would generally be considered qualified to evaluate and diagnose ADHD provided they have comprehensive training in the differential diagnosis of ADHD and direct experience with an adolescent or adult ADHD population: psychologists, neuropsychologists, psychiatrists, and other relevantly trained medical doctors. It may be appropriate to use a clinical team approach consisting of a variety of educational, medical, and counseling professionals with training in the evaluation of ADHD in adolescents and adults. Use of diagnostic terminology indicating an ADHD by someone whose training and experience are not in these fields is not acceptable. It is also not appropriate for professionals to evaluate members of their own families.

The name, title, and professional credentials of the evaluator — including information about license or certification as well as the area of specialization, employment, and state or province in which the individual practices should be clearly stated in the documentation. All reports should be on letterhead, typed, dated, signed, and otherwise legible.

II. Documentation Must Be Current

Because the provision of all reasonable accommodations and services is based upon the Bar Examining Committee's (BEC) assessment of the *current* impact of the disability on bar examination performance, it is in a candidate's best interest to provide recent and appropriate documentation. In most cases, this means that a diagnostic evaluation must have been completed within the past three years. Flexibility in accepting documentation that is more than three years old may be important under certain conditions if the previous assessment is applicable to the current or anticipated setting. If documentation is inadequate in scope or content, or does not address the individual's current level of functioning and need for accommodations, reevaluation may be required. Furthermore, observed changes may have occurred in the individual's performance since the previous assessment, or new medications may have been prescribed or discontinued since the previous assessment was conducted. In such cases, it will be necessary to update the evaluation report. The update must include a detailed assessment of the current impact of the ADHD and an interpretative summary of relevant information (see Section III, G) and the previous diagnostic report. If necessary, BEC consultants will recommend what aspects of the documentation need to be updated or augmented in order to be reviewed more fully.

III. Documentation Necessary to Substantiate the Diagnosis Must be Comprehensive

A. Evidence of Early Impairment

Because ADHD is, by definition in the DSM-IV, first exhibited in childhood (although it may not have been formally diagnosed) and manifests itself in more than one setting, relevant historical information is essential. The following should be included in a comprehensive assessment: clinical summary of objective historical information, establishing symptomology indicative of ADHD throughout childhood, adolescence, and adulthood as garnered from transcripts, report cards, teacher comments, tutoring evaluations, and past psychoeducational testing; and third party interviews when available.

B. Evidence of Current Impairment

In addition to providing evidence of a childhood history of an impairment, the following areas must be investigated:

1. **Statement of Presenting Problem**
   A history of the individual's presenting attentional symptoms should be provided, including evidence of ongoing impulsive/hyperactive or inattentive behaviors that significantly impair functioning in two or more settings.

2. **Diagnostic Interview**
   The information collected for the summary of the diagnostic interview should consist of more than self-report, as information from third party sources is critical in the diagnosis of ADHD. The diagnostic interview with information from a variety of sources should include, but not necessarily be limited to, the following:

- history of presenting attentional symptoms, including evidence of ongoing impulsive/hyperactive or inattentive behavior that has significantly impaired functioning over time
- developmental history
- family history for presence of ADHD and other educational, learning, physical, or psychological difficulties deemed relevant by the examiner
- relevant medical and medication history, including the absence of a medical basis for the symptoms being evaluated
- relevant psychosocial history and any relevant interventions
- a thorough academic history of elementary, secondary, and postsecondary education
- a review of prior psychoeducational test reports to determine whether a pattern of strengths or weaknesses is supportive of attention or learning problems
- relevant employment history
- description of current functional limitations pertaining to an educational setting that are presumably a direct result of problems with attention
- relevant history of prior therapy

C. Alternative Diagnoses or Explanations Should Be Ruled Out

The evaluator must investigate and discuss the possibility of dual diagnoses and alternative or coexisting mood, behavioral, neurological, and/or personality disorders that may confound the diagnosis of ADHD. This process should include exploration of possible alternative diagnoses and medical and psychiatric disorders as well as educational and cultural factors affecting the individual that may result in behaviors mimicking an Attention-Deficit/Hyperactivity Disorder.

D. Relevant Testing Information Must Be Provided

The assessment of the individual must not only establish a diagnosis of ADHD, but must also demonstrate the current impact of the ADHD on an individual's ability to take standardized tests. In addition, neuropsychological or psychoeducational assessment is important in determining the current impact of the disorder on an individual's ability to function in academically related settings. The BEC views a complete psychoeducational assessment as the primary tool, particularly in the K-12 academic setting, for determining the degree to which the ADHD currently impacts the individual relative to taking standardized tests. The evaluator must objectively review and include with the evaluation report relevant background information to support the diagnosis and its impact within the current educational environment. If grade equivalents are reported, they must be accompanied by standard scores and/or percentiles.

Test scores or subtest scores alone should not be used as a sole measure for the diagnostic decision regarding ADHD. Selected subtest scores from measures of intellectual ability, memory functions tests, attention or tracking tests, or continuous performance tests do not in and of themselves establish the presence or absence of ADHD. Checklists and/or surveys can serve to supplement the diagnostic profile but in and of themselves are not adequate for the diagnosis of ADHD and do not substitute for clinical observations and sound diagnostic judgment. All data must logically reflect a substantial limitation to learning for which the individual is requesting the accommodation.

E. Identification of DSM-IV Criteria

According to the DSM-IV, "the essential feature of ADHD is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development." A diagnostic report should include a review and discussion of the DSM-IV criteria for ADHD both currently and retrospectively and specify which symptoms are present (see Appendix A for DSM-IV criteria).

In diagnosing ADHD, it is particularly important to address the following criteria:

- symptoms of hyperactivity/impulsivity or inattention that cause impairment that must have been present in childhood
- current symptoms that have been present for at least the past six months
- impairment from the symptoms present in two or more settings (for example, school, work, home)

- clear evidence of significant impairment in social, academic, or occupational functioning

- symptoms that do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

F. Documentation Must Include a Specific Diagnosis

The report must include a specific diagnosis of ADHD based on the DSM-IV diagnostic criteria. The diagnostician should use direct language in the diagnosis of ADHD, avoiding the use of such terms as "suggests, is indicative of, or attention problems."

Individuals who report only problems with organization, test anxiety, memory or concentration in selective situations do not fit the prescribed diagnostic criteria for ADHD. Given that many individuals benefit from prescribed medications and therapies, a positive response to medication by itself does not confirm a diagnosis, nor does the use of medication in and of itself either support or negate the need for accommodation(s).

G. An Interpretative Summary Must Be Provided

A well-written interpretative summary based on a comprehensive evaluative process is a necessary component of the documentation. Because ADHD is in many ways a diagnosis that is based upon the interpretation of historical data and observation, as well as other diagnostic information, it is essential that professional judgment be utilized in the development of a summary, which must include:

1. demonstration of the evaluator having ruled out alternative explanations for inattentiveness, impulsivity, and/or hyperactivity as a result of psychological or medical disorders or noncognitive factors

2. indication of how patterns of inattentiveness, impulsivity, and/or hyperactivity across the life span and across settings are used to determine the presence of ADHD

3. indication of whether or not the candidate was evaluated while on medication, and whether or not the prescribed treatment produced a positive response

4. indication and discussion of the substantial limitation to learning presented by the ADHD and the degree to which it affects the individual in the testing context for which accommodations are being requested

5. indication as to why specific accommodations are needed and how the effects of ADHD symptoms, as designated by the DSM-IV, are mediated by the accommodations.

IV. Each Accommodation Recommended by the Evaluator Must Include a Rationale

The evaluator must describe the impact, if any, of the diagnosed ADHD on a specific major life activity as well as the degree of impact on the individual. The diagnostic report must include specific recommendations for accommodations that are realistic and that postsecondary institutions, and examining, certifying, and licensing agencies can reasonably provide. A detailed explanation as to why each accommodation is recommended must be provided and should be correlated with specific functional limitations determined through interview, observation, and/or testing. Although prior documentation may have been useful in determining appropriate services in the past, current documentation must validate the need for services based on the individual's *present* level of functioning in the educational setting. A school plan such as an Individualized Education Program (IEP) or a 504 plan is insufficient documentation in and of itself but can be included as part of a more comprehensive evaluative report. The documentation must include any record of prior accommodations or auxiliary aids, including information about specific conditions under which the accommodations were used (e.g., standardized testing, final exams, licensing or certification examinations) and whether or not they benefited the individual. However, a prior history of accommodations without demonstration of a current need does not in itself warrant the provision of like accommodations. If no prior accommodations were provided, the qualified professional and/or the candidate must include a detailed explanation of why no accommodations were needed in the past and why accommodations are needed at this time.

Because of the challenge of distinguishing normal behaviors and developmental patterns of adolescents and adults (e.g., procrastination, disorganization, distractibility, restlessness, boredom, academic under-achievement or failure, low self-esteem, chronic tardiness or inattendance) from clinically significant impairment, a multifaceted evaluation should address the intensity and frequency of the symptoms and whether these behaviors constitute an impairment in a major life activity.

If the requested accommodations are not clearly identified in the diagnostic report, the BEC will seek clarification, and if necessary, more information. The BEC will make final determination of whether appropriate and reasonable accommodations are warranted and can be provided to the individual.

V. Confidentiality

The BEC will adhere to its confidentiality policies regarding its responsibility to maintain confidentiality of the evaluation and will not release any part of the documentation without the candidate's informed consent or under compulsion of legal process.

APPENDIX A

DSM-IV Diagnostic Criteria for ADHD

The following diagnostic criteria for ADHD are specified in the DSM-IV:

A. Either (1) or (2):

1. six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

   Inattention

   a. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities

   b. often has difficulty sustaining attention in tasks or play activities

   c. often does not seem to listen when spoken to directly

   d. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)

   e. often has difficulty organizing tasks and activities

   f. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

   g. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)

   h. is often easily distracted by extraneous stimuli

   i. is often forgetful in daily activities

2. six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

   Hyperactivity

   a. often fidgets with hands or feet or squirms in seat

   b. often leaves seat in classroom or in other situations in which remaining seated is expected

c. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

d. often has difficulty playing or engaging in leisure activities quietly

e. is often "on the go"or often acts as if "driven by a motor"

f. often talks excessively

Impulsivity

g. often blurts out answers before questions have been completed

h. often has difficulty awaiting turn

i. often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

The DSM-IV specifies a code *designation* based on type:

314.01 **Attention-Deficit/Hyperactivity Disorder, Combined Type:** if both Criteria A1 and A2 are met for the past 6 months

314.00 **Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type:** if Criterion A1 is met but Criterion A2 is not met for the past 6 months

314.01 **Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type:** if Criterion A2 is met but Criterion A1 is not met for the past 6 months.

Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.

314.9 **Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified:** This category is for disorders with prominent symptoms of

inattention or hyperactivity-impulsivity that do not meet criteria for Attention-Deficit/Hyperactivity Disorder.

APPENDIX B

Recommendations for Consumers

1. For assistance in finding a qualified professional:

    a. contact the disability services coordinator at a college or university for possible referral sources; and /or

    b. contact a physican who may be able to refer you to a qualified professional with demonstrated expertise in ADHD.

2. In selecting a qualified professional:

    a. ask what experience and training he or she has had diagnosing adolescents and adults

    b. ask whether he or she has training in differential diagnosis and the full range of psychiatric disorders. Clinicians typically qualified to diagnose ADHD may include clinical psychologists, physicians (including psychiatrists), and neuropsychologists

    c. ask whether he or she has ever worked with a post-secondary disability service provider or with the agency to which you are providing documentation

    d. ask whether you will receive a comprehensive written report.

3. In working with the professional:

    . take a copy of these guidelines to the professional

    a. be prepared to be forthcoming, thorough, and honest with requested information.

4. As follow-up to the assessment by the professional:

    . schedule a meeting to discuss the results, recommendations, and possible treatment

    a. request additional resources, support group information, and publications if you need them

    b. maintain a personal file of your records and reports

    c. be aware that any receiving institution or agency has a responsibility to maintain confidentiality.

APPENDIX C

Assessing Adolescents and Adults with ADHD

The diagnosis of ADHD is strongly dependent on a clinical interview in conjunction with a variety of formal and informal measures. Since there is no one test, or specified combination of tests, for determining ADHD, the diagnosis of an attention deficit/hyperactivity disorder (ADHD) requires a multifaceted approach. Any tests that are selected by the evaluator should be technically accurate, reliable, valid, and standardized on the appropriate norm group. The following list includes five broad domains that are frequently explored when arriving at an ADHD diagnosis. This listing is provided as a helpful resource but is not intended to be definitive or exhaustive.

1. **Clinical interview** - The evaluator should: 1) provide retrospective confirmation of ADHD; 2) establish relevant developmental and academic markers; 3) determine any other co-existing disorders; and 4) rule out other problems that may mimic ADHD.

Specific areas to be addressed include:

- family history
- results of a neuro-medical history
- presence of ADHD symptoms since childhood
- presence of ADHD symptoms in last 6 months
- evidence that symptoms cause a "significant impairment" over time
- results of clinical observation for hyperactive behavior, impulsive speech, distractibility
- extent of functional impairment across settings (e.g., academic, occupational, social)
- an accounting for periods in which student was symptom-free
- presence of other psychiatric conditions (mood or anxiety disorders, substance abuse, etc.)
- indication that symptoms are not due to other conditions (e.g., depression, drug use, neuromedical problems)
- relevant medication history
- determination of which remediation approaches and/or compensating strategies are and are not currently effective.
- determination of what accommodations, if any, have alleviated symptoms in the past or in the present setting.

2. **Rating scales** - Self-rated or interviewer-rated scales for categorizing and quantifying the nature of the impairment may be useful in conjunction with other data.
Selected examples include:

- *Wender Utah Rating Scale*
- *Brown Attention-Activation Disorder Scale*
- *Beck Anxiety Inventory*
- *Hamilton's Depression Rating Scale*
- *Conners Teacher Rating Scale (age 3-17 years)*
- *Conners Parent Rating Scale (age 3-17 years)*

3. **Neuro-psychological and psycho-educational testing** - Cognitive and achievement profiles may suggest attention or information processing deficits. No single test or subtest should be used as the sole basis for a diagnostic decision.
Acceptable instruments include, but are not limited to:

Aptitude/Cognitive Ability

- *Wechsler Adult Intelligence Scale - III (WAIS-III)*
- *Woodcock-Johnson Psychoeducational Battery - Revised: Tests of Cognitive Ability*
- *Kaufman Adolescent and Adult Intelligence Test*

Academic Achievement

- *Scholastic Abilities Test for Adults (SATA)*
- *Stanford Test of Academic Skills (TASK)*
- *Woodcock-Johnson Psychoeducational Battery - Revised: Tests of Achievement*
- *Wechsler Individual Achievement Test (WIAT)*
  or specific achievement tests such as
- *Nelson-Denny Reading Skills Test*
- *Stanford Diagnostic Mathematics Test*
- *Test of Written Language - 3 (TOWL-3)*
- *Woodcock Reading Mastery Tests - Revised*

Information Processing

- *Detroit Tests of Learning Aptitude - 3 (DTLA-3) or Detroit Tests of Learning Aptitude - Adult (DTLA-A).*
- *Information from subtests on WAIS-R or Woodcock-Johnson Psychoeducational Battery - Revised: Tests of Cognitive Ability*, as well as

other relevant instruments, may be useful when interpreted within the context of other diagnostic information.

4. **Medical evaluation** - Medical disorders may cause symptoms resembling ADHD. Therefore, it may be important to rule out the following:

- Neuroendocrine disorders (e.g., thyroid dysfunction)
- Neurologic disorders
- Impact of medication on attention if tried, and under what circumstances

5. **Collateral information** - Include third party sources which can be helpful to determine the presence or absence of ADHD in childhood.

- Description of current symptoms (e.g., by spouse, teachers, employer)
- Description of childhood symptoms (e.g., parent)
- Information from old school and report cards and transcripts